missed MIs represent a major cause of legal liability. Similarly, the advice to interpret an elevated troponin level in the clinical context is wise, yet may have a limited effect—estimates of pre-test probability have a high interobserver variability (3). Physicians often do not make formal quantitative calculations in practice (4) and make errors when they do (5).

Troponins, as currently used, have an excellent negative predictive value, but poor positive predictive value. The absolute value of troponin and the degree of increase on sequential testing are helpful in diagnosing acute MI, but may be less helpful in confirming thrombotic ACS as the cause. We have observed cases of acute troponin I increases as great as 10 ng/ml with stroke, diabetic ketoacidosis, and heart failure. As the key therapeutic decision to provide antithrombotics or urgent revascularization usually occurs on presentation, and such therapies can only benefit patients with significant ACS, practicing clinicians need a second confirmatory test for ACS. Such a test should be less severely affected by sepsis, tachyarrhythmia, hypotension, renal failure, chronic coronary disease, demand ischemia, heart failure, or cardiomyopathy, even if it is insensitive to small amounts of myonecrosis. That test, arguably, is the creatine kinase–myocardial band and index.

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Reply

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